Senate Commerce and Labor Committee 1

Amendment No. 1 to SB2165

Johnson
Signature of Sponsor

AMEND Senate Bill No. 2165* House Bill No. 2355

by deleting all language after the enacting clause and substituting instead the following:

SECTION 1. Tennessee Code Annotated, Section 56-7-2360, is amended by deleting the section and substituting the following:

(a)

(1) As used in this section, unless the context otherwise requires:

(A) "Aggregate lifetime limit" means a dollar limitation on the total amount that may be paid for benefits under a health plan with respect to an individual or other coverage unit;

(B) "Annual limit" means a dollar limitation on the total amount that may be paid for benefits in a twelve-month period under a health plan with respect to an individual or other coverage unit;

(C) "Classification of benefits" means inpatient in-network benefits, inpatient out-of-network benefits, outpatient in-network benefits, outpatient out-of-network benefits, prescription drug benefits, and emergency care benefits. These classifications of benefits are the only classifications that may be used except that there may be sub-classifications within both outpatient classifications differentiating office visits from other outpatient items and services, including outpatient surgery, facility charges for day treatment centers, laboratory charges, and other medical items;

(D) "Financial requirement" includes deductibles, copayments,

Amendment No. 1 to SB2165

Johnson
Signature of Sponsor

AMEND Senate Bill No. 2165* House Bill No. 2355

coinsurance, and out-of-pocket expenses, but excludes an aggregate lifetime limit and an annual limit;

(E) "Health benefit plan" means any hospital or medical expense policy, health, hospital or medical service corporation contract, a policy or agreement entered into by a health insurer or a health maintenance organization contract offered by an employer, other plans administered by the state government, or any certificate issued under the policies, contracts, or plans;

(F) "Health insurance carrier" means any entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner of commerce and insurance, that contracts with healthcare providers in connection with a plan of health insurance, health benefits, or health services;

(G) "Mental health or alcoholism or drug dependency benefits" means benefits for the treatment of any condition or disorder that involves a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental disorders section of the current edition of the International Classification of Disease or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders;

(H) "Non-quantitative treatment limitations," or "NQTLs," are limitations that are not expressed numerically, but otherwise limit the scope or duration of benefits for treatment. NQTLs include, but are not

limited to:

(i) Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;

(ii) Formulary design for prescription drugs;

(iii) Tier design for plans with multiple network tiers, including preferred providers and participating providers, and network tier design;

(iv) Standards for provider admission to participate in a network, including reimbursement rates;

(v) Plan methods for determining usual, customary, and reasonable charges;

(vi) Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective, that are also known as fail-first policies or step therapy protocols;

(vii) Exclusions based on failure to complete a course of treatment;

(viii) Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage;

(ix) In- and out-of-network geographic limitations;

(x) Standards for providing access to out-of-network providers;

(xi) Limitations on inpatient services for situations where

the participant is a threat to self or others;

(xii) Exclusions for court-ordered and involuntary holds;

(xiii) Experimental treatment limitations;

(xiv) Service coding;

(xv) Exclusions for services provided by clinical social workers;

(xvi) Network adequacy; and

(xvii) Provider reimbursement rates, including rates of reimbursement for mental health and substance abuse services in primary care;

(I) "Predominant" means application to more than one-half (1/2) of such type of limit or requirement;

(J) "Substantially all" means application to at least two-thirds (2/3) of all medical or surgical benefits in a classification; and

(K) "Treatment limitation" includes limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.

(2) In addition to any other requirement of law concerning coverage of mental health or mental illness benefits or alcoholism or drug dependency benefits, including, but not limited to, §§ 56-7-2601 and 56-7-2602, any individual or group health benefit plan issued by a health insurance carrier regulated pursuant to this title shall provide coverage for mental health or alcoholism or drug dependency services in compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) (Pub. L. No. 110-343) found at 42 U.S.C. § 300gg-26 and its implementing regulations found at 45 CFR § 146.136 and 45 CFR § 147.160.

(b) Nothing in subsection (a) prohibits an employee health benefit plan, or a plan issuer offering an individual or group health plan from utilizing managed care practices for the delivery of benefits required under this section, as long as that for any utilization review or benefit determination for the treatment of alcoholism or drug dependence the clinical review criteria is the most recent Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions established by the American Society of Addiction Medicine or other evidence-based clinical guidelines, such as those referenced by the federal substance abuse and mental health services administration (SAMHSA). No additional criteria other than in this subsection (b) may be used during utilization review or benefit determination for treatment of substance use disorders.

(c) The mandate to provide coverage for mental health services does not apply with respect to a group health plan if the application of the mandate to the plan results in an increase in the cost under the plan of more than one percent (1%). Documentation of the increase in cost must be filed with the department after twelve (12) months of experience. If the commissioner determines that the increase in cost is a result of the requirements of this section, the commissioner or the commissioner's designee shall issue a letter to the issuer of the plan stating that the plan does not have to comply with the mandate set out in this section. The issuer may appeal the letter as final agency action pursuant to the Uniform Administrative Procedures Act, compiled in title 4, chapter 5.

(d) The department of commerce and insurance shall implement and enforce applicable provisions of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) (Pub. L. No. 110-343), this section, and §§ 56-7-2601 and 56-7-2602, which include:

(1) Ensuring compliance by individual and group health benefit plans;

(2) Detecting possible violations of the law by individual and group health

benefit plans;

(3) Accepting, evaluating, and responding to complaints regarding such violations; and

(4) Maintaining and regularly reviewing for possible parity violations a publicly available consumer complaint log regarding mental health or alcoholism or drug dependency coverage; provided, that individually identifiable information shall be excluded.

(e) Not later than January 31, 2020, the department shall issue a report to the general assembly and provide an educational presentation to the general assembly. The report and presentation shall:

(1) Discuss the methodology the department is using to check for compliance with the MHPAEA, and any federal regulations or guidance relating to the compliance and oversight of the MHPAEA, including 45 CFR 146.136;

(2) Discuss the methodology the department uses to check for compliance with this section and §§ 56-7-2601 and 56-7-2602;

(3) Identify market conduct examinations conducted or completed during the preceding twelve-month period regarding compliance with parity in mental health or alcoholism or drug dependency benefits under state and federal laws and summarize the results of such market conduct examinations. Individually identifiable information shall be excluded from the reports consistent with federal privacy protections, including, but not limited to, 42 U.S.C. § 290dd-2 and regulations found at 42 CFR § 2.1 through 42 CFR § 2.67. This discussion shall include:

(A) The number of market conduct examinations initiated and completed;

(B) The benefit classifications examined by each market conduct

examination;

(C) The subject matter of each market conduct examination, including quantitative and non-quantitative treatment limitations; and

(D) A summary of the basis for the final decision rendered in each market conduct examination;

(4) Detail any educational or corrective actions the department of commerce and insurance has taken to ensure health benefit plan compliance with this section, the MHPAEA, 42 U.S.C. § 18031(j), and §§ 56-7-2601 and 56-7-2602;

(5) Detail the department's educational approaches relating to informing the public about mental health or alcoholism or drug dependence parity protections under state and federal law; and

(6) Describe how the department examines any provider or consumer complaints related to denials or restrictions to care for opioid use disorder treatment for possible violations of this section, the MHPAEA, 42 U.S.C. § 18031(j), and §§ 56-7-2601 and 56-7-2602, including complaints regarding, but not limited to:

(A) Denials of claims for residential treatment or other inpatient treatment on the grounds that such a level of care is not medically necessary;

(B) Claims for residential treatment or other inpatient treatment that were approved but for a fewer number of days than requested;

(C) Denials of claims for residential treatment or other inpatient treatment because the beneficiary had not first attempted outpatient treatment, medication, or a combination of outpatient treatment and medication;

(D) Denials of claims for medications such as buprenorphine or naltrexone on the grounds that they are not medically necessary;

(E) Step therapy requirements imposed before buprenorphine or naltrexone is approved; and

(F) Prior authorization requirements imposed on claims for buprenorphine or naltrexone, including those imposed because of safety risks associated with buprenorphine.

(f) The report issued pursuant to subsection (e) must be written in non-technical, readily understandable language and shall be made available to the public by posting the report on the department's website and by other means as the department finds appropriate, provided that the department must redact the names of any health insurance carriers and any other entities that have entered into a contract with a health insurance carrier.

(g) Benefits under this section shall not be denied for care for confinement provided in a hospital owned or operated by this state that is especially intended for use in the diagnosis, care, and treatment of psychiatric, mental, or nervous disorders.

(h) Nothing in this section applies to accident-only, specified disease, hospital indemnity, medicare supplement, long-term care, or other limited benefit hospital insurance policies.

(i) The commissioner is authorized to promulgate rules to effectuate the purposes of this section. The rules must be promulgated in accordance with the Uniform Administrative Procedures Act, compiled in title 4, chapter 5.

(j) Nothing in this section shall be construed as requiring the disclosure of any information that would violate 42 U.S.C. § 290dd-2 and regulations found at 42 CFR § 2.1 through 42 CFR § 2.67.

SECTION 2. Tennessee Code Annotated, Title 56, Chapter 7, Part 10, is amended by

adding the following as a new section:

(a) Whenever the commissioner performs a market conduct examination of a health insurance carrier that issues a health benefit plan under the jurisdiction of the department of commerce and insurance for compliance with § 56-7-2360, the examination shall include, but not be limited to, the following information:

(1) A description of the process used to develop or select the medical necessity criteria for mental health or alcoholism or drug dependency benefits and the process used to develop or select the medical necessity criteria for medical and surgical benefits;

(2) Identification of all non-quantitative treatment limitations (NQTLs) that are applied to both mental health or alcoholism or drug dependency benefits and medical and surgical benefits; and

(3) The results of any analysis that may have been performed by a health insurance carrier that demonstrates that for the medical necessity criteria described in subdivision (a)(1) and for each NQTL identified in subdivision (a)(2), as written and in operation, the processes, strategies, evidentiary standards, or other factors used to apply the medical necessity criteria and each NQTL to mental health or alcoholism or drug dependency benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used to apply the medical necessity criteria and each NQTL, as written and in operation, to medical and surgical benefits. The results of the analysis may:

(A) Identify the factors used to determine that an NQTL will apply to a benefit, including factors that were considered but rejected;

(B) Identify and define the specific evidentiary standards used to define the factors and any other evidentiary standards relied upon in

designing each NQTL;

(C) Identify and describe the methods and analyses used, including the results of any relevant analyses, to determine that the processes and strategies used to design each NQTL as written for mental health or alcoholism or drug dependency benefits are comparable to, and no more stringent than, the processes and strategies used to design each NQTL as written for medical and surgical benefits;

(D) Identify and describe the methods and analyses used, including the results of any relevant analyses, to determine that processes and strategies used to apply each NQTL in operation for mental health or alcoholism or drug dependency benefits are comparable to, and no more stringent than, the processes or strategies used to apply each NQTL in operation for medical and surgical benefits;

(E) Disclose the specific findings and conclusions reached by the health insurance carrier that the results of any relevant analyses under this subsection indicate that the health insurance carrier is in compliance with this section and the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) (Pub .L. No. 110-343), and its implementing regulations, including 45 CFR 146.136 and any other applicable regulations; and

(F) Identify any other information necessary to clarify data provided in accordance with this section requested by the commissioner, including information that may be "proprietary" or have "commercial value." Any information submitted that is proprietary shall not be made a public record under title 10, chapter 7.

(b) The health insurance carrier's chief executive officer and chief medical officer

shall sign a certification that affirms that the health insurance carrier has completed a comprehensive review of its administrative practices for the prior calendar year for compliance with the necessary provisions of this section, §§ 56-7-2601 and 56-7-2602, and the MHPAEA.

(c) Separate NQTLs that apply to mental health or alcohol or drug dependency benefits but do not apply to medical and surgical benefits within any classification of benefits are not permitted.

SECTION 3. This act shall take effect January 1, 2019, the public welfare requiring it. This act shall apply to policies and contracts entered into or renewed on and after January 1, 2019.